

EDITORIALS

workup) controversy. Rudd and Marton favor the latter approach, citing the rarity of curable hypertension and frequent failures after surgical manipulation of renovascular hypertension. I share their view: costs of universal extensive diagnostic workup are prohibitive in this era of cost accountability. *Correctable* diagnosis can be suspected by careful clinical evaluation and minimal laboratory examination.

A detailed and enlightened discussion of the critical problem of *patient compliance* is a high point. In my experience there is no substitute for a zealous nurse with a hot telephone to tweak those hypertensive patients who miss appointments. They must be hounded to discover whether they have become ill, whether the medication is causing embarrassing or otherwise undesirable adverse side effects or whether they are simply too embarrassed to come in because they have failed to take the medication. Compliance is a function of physician perseverance and determination.

As stated earlier, patients must be intellectually and emotionally convinced to continue life-long therapy, yet they cannot be alarmed into disability. The authors also make the key point that therapeutic programs must be kept as simple as possible and tailored to the life-style of the patient. All clinicians have found it valuable to have blood pressures taken at home by reliable family members who are involved with the patient personally and who are convinced of the importance of sustained treatment.

The final section of the paper, on professional variability, presents an incredible array of physician *malfunctions*. These range from poor (or absent) record keeping, failure to recognize hypertension, casual attitude about patient education and failure to pursue those patients who are not cooperative.

The problem of educating physicians about hypertension is real. There is a certain apathy among clinicians about diseases that have few obvious symptoms yet which cause damage at a subtle, nondramatic pace (until the patient gets a myocardial infarction or suffers a stroke). It is an especially unappealing situation when an asymptomatic patient is obliged to take medication that may make him unhappy or even sick. It is a no win situation in the short haul; but in hypertension it is the long haul that is important.

After this doleful recitation the authors nibble at the solution to the problems in two concluding paragraphs. Once again they cite the importance

of physician education as the chief factor in solving this multitude of nontraditional pitfalls.

It is a thoroughly readable paper, and it is referenced with a vengeance.

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A New Kind of Melting Pot

SUMMER IS A TIME for reflection and even some dreaming. The slackened pace, if one is lucky enough to have it slacken, provides an occasional moment when one can stand back and look at the forest made up of all the trees that come to one's attention in the course of daily events. For example, if one stands back, reflects and dreams, one might sense that America may be creating a new kind of melting pot, with a new place in the world—with new responsibilities and opportunities for medicine.

America has long been described as a melting pot. For years it was able to absorb and integrate wave after wave of immigrants, primarily from Europe. Most of these entered the country legally and earned their place in American society by working long and hard, as indeed did the earlier settlers who developed the principles of freedom, enterprise and law which served to make the nation great—in fact the envy of the world. Our industrial products were the mark of a new standard of living among even the more advanced nations, and American efficiency was what made this production possible on such a scale. Even today our know-how and expertise are courted by other nations, including the USSR and the People's Republic of China as these nations seek to improve the standard of living of their peoples. The American dollar was pegged to gold and the expression *sound as a dollar* meant something more than it does today.

But this kind of a melting pot seems to have passed its zenith and to be approaching some kind of nadir if one uses only the above criteria. Illegal aliens abound, particularly in the West and parts of the South. Many of these people work hard but do not pay taxes, and many require support through our public programs. Illegal entry of persons and contraband seems to occur almost as if the borders did not exist. Persons of Mexican birth or ancestry will soon be a

majority in many parts of the Southwest, and this will amount to a kind of extension of that country into the United States. The work ethic is clearly changing as everyone tries to get more for working less, and as we give various groups in the population special competitive advantages to compensate for educational or other disadvantages. The two major countries we defeated in World War II have recovered with our help and are now efficiently outproducing us—beating us at our own game, as it were. For example, better and more efficient foreign automobiles are outselling American ones in the American market, clearly a change from what used to be the case. A persistent foreign trade deficit, worsened by the oil crisis, has replaced a favorable balance. Foreign capital is now being invested in the United States on a growing scale, favored by the relative cheapness of the dollar—with potential for good and bad that is unpredictable at this time.

It would seem that the so-called American melting pot is moving from its former and familiar independence to unfamiliar interdependence. It seems inevitable, as time goes on and with things being the way they are, that “foreigners” will control more and more of our land, our capital, our business and industry, and our political system. As this occurs America’s melting pot will come to have more international dimensions. It is noteworthy that this will be at a time when other nations, including those of the Third World, will join China and Russia in striving to reach the kind of living standard America has shown to be possible, and then they too will have all the problems of its success—inefficiencies due to overregulation, underproductivity, environmental pollution and unavoidable dependence for some essential resources upon other nations which may or may not be cooperative.

If this is to occur, where is there a role for medicine? Health, well-being and personal fulfillment are essential ingredients of the higher standard of living that a new worldwide melting pot will strive to achieve. They are also what physicians seek for their patients and for the public. Medicine with all its branches and ramifications is the human life science for health, well-being and personal fulfillment, and physicians together with other health professionals profess and practice this science and its art in the human society. If, when and as the American melting pot goes international, there will surely be new opportunities and responsibilities for American

medicine throughout the world as well as at home. It certainly is not too early to dream—and it may not be too early to think and even begin to plan.

—MSMW

Rheumatic Disease—A Case of the Soil and the Seed

A SMALL RENAISSANCE is occurring in clinical rheumatology. This is largely due to better recognition of two distinctive forms of rheumatic disease. Identification of the various arthropathies associated with calcium pyrophosphate deposition disease has thrust this cartilage disorder to the fore.¹ Also, a cleaner delineation of the seronegative spondyloarthropathies as a group of diseases “running in families” has led to the realization that many examples of *forme fruste* rheumatic disease belong in this category.² Dr. Calin’s article elsewhere in this issue focuses on this latter group of diseases and, in so doing, indicates how the recognition of a genetic susceptibility to acute or chronic rheumatic disease naturally leads to better or earlier diagnosis, as well as to a more scientific pursuit of pathogenesis.

Diagnostic criteria might well be considered to be the Achilles’ heel of rheumatology. So many forms of arthritis lack objective and distinctive markers. Recognition of the association between the seronegative spondyloarthropathies and HLA-B27 has led to a widening of our diagnostic horizons and has pointed to the need for reappraising many conventional clinical criteria for identifying ankylosing spondylitis and the Reiter syndrome. As Dr. Calin indicates, epidemiologic data on this group of rheumatic diseases will now have to be reexamined using broader criteria including tissue typing as well as radiographic and scintigraphic methods. Indeed the old accepted adage of “radiographic sacroiliitis equals ankylosing spondylitis” needs to be reappraised, and more sensitive diagnostic tests should be designed to detect pre-radiographic osteoarticular inflammations.

The main theme of Dr. Calin’s article is that rheumatic disease results from an interaction between a genetically predisposed host and environmental factors—the “soil and seed.” This concept is based on rapidly increasing evidence indicating that a large variety of acquired human